

OFFICIAL GAZETTE



GOVERNMENT OF GOA

EXTRAORDINARY

GOVERNMENT OF GOA

Department of Social Welfare

Notification

5/2/91-SWD

The Government of Goa is hereby pleased to frame the following rules to regulate the Scheme for Grant of Financial Assistance to persons with severe disabilities, namely:—

1. *Short title applicability and commencement.*— (1) These rules may be called the Goa (Grant of Financial Assistance to persons with Severe Disabilities) Rules, 1997.

(2) They shall apply to the whole of the State of the Goa.

(3) They shall come into force with immediate effect.

2. *Object.*— The objectives of the Scheme is to promote economic self reliance among the persons with severe disabilities by granting suitable financial assistance to them.

3. *Definitions.*— In these rules, unless the context otherwise requires,—

(a) 'Government' means the Government of the State of Goa;

(b) 'Director' means the Director of Social Welfare, Directorate of Social Welfare, of the Government;

(c) 'Severe disability' means at least one of the following types of disabilities:— (1) 100% Locomotor disabilities including disabilities due to leprosy. (However the person should be leprosy cured), (2) 100% Visual disability and (3) Mental Retardation declared so by an authorised medical specialist either from the Medical Board at Asilo Hospital, Mapusa or Hospicio Hospital, Margao, or Goa Medical College, Bambolim, or Institute of Psychiatry and Human Behaviour, Altinho, Panaji.

(d) 'Family' means the person with severe disabilities, his/her parents or guardians, husband/wife. (if applicant is married/applicant's unmarried brother(s), and/or sister(s) (if any) and unmarried children (if any).

4. *Conditions of eligibility.*— To be eligible to apply for the financial assistance under the Scheme, the applicant must satisfy the following conditions, namely:—

(1) The applicant should be a bonafide resident of the State of Goa by birth or by marriage or by continuous domicile of at least 15 years.

(2) He should be suffering from any of the severe disabilities as defined in rule 3 above.

(3) He should have completed 10 years of age.

(4) The total family income of the applicant from all sources should not exceed Rs. 25,000/- per annum.

5. (1) The person with severe disability shall be granted a financial assistance of Rs. 20,000/- (Rupees twenty thousand only), which shall be deposited jointly in the names of the Director (by designation) and the concerned beneficiary (Parents/guardians of the beneficiary in case of minor applicants with mental retardation) as a fixed deposit for a period of ten years and interest which accrues on this fixed deposit shall be credited to the Bank account of the beneficiary in the same Bank, every three months. After completion of the period of 10 years, the amount of fixed deposit of Rs. 20,000/- shall be transferred to the Bank account of the concerned beneficiary which may be utilized by the beneficiary as per his/her wish. However, the Director shall have an authority to stop/cancel benefits of the financial assistance under the Scheme in the event of occurrence/detection of conditions/situations as specified in rule 9. In this case the fixed deposit shall be withdrawn by the Director and deposited in the Government Treasury. Such an arrangement/agreement shall be entered into by the Director and the concerned Nationalised Bank in which the beneficiary desires to deposit the amount before the deposit of financial assistance in the concerned Bank. Arrangement shall also be made by issuing standing instructions to the concerned Bank to transfer an interest which accrues on the fixed deposits, once every three months, to the Bank account of the beneficiary.

(2) The grant of financial assistance shall be sanctioned by the Director and shall be drawn and disbursed to the party concerned as mentioned in sub-rule (1) above, by the Block Development Officer of the respective Block.

6. *Mode of applying.*— An application for grant of financial assistance to a person with severe disability under these rules shall be made in the form as specified in Appendix - I. The application should be submitted to the Directorate of Social Welfare through the respective Block Development Officer. The application shall be accompanied by the following documents:—

- (1) Medical Certificate in the form of Appendix - IV or V or VI or VII (as applicable) issued either by the Medical Board at Asilo Hospital, Mapusa, or Hospicio Hospital, Margao, or by the Head of the concerned Department of the Goa Medical College and Hospital, Bambolim or by the Director of Institute of Psychiatry and Human Behaviour, Altinho, Panaji.
- (2) A Certificate from the concerned Block Development Officer in Appendix - II to the effect that the applicant is not in receipt of any type of financial assistance like the Dayanand Smruti Niradhar Madat Yojana or financial assistance released by the Panchayats or Rural Development Agency or any such other financial assistance.
- (3) Family Income Certificate.
- (4) Birth Certificate.
- (5) Declaration in Appendix - II.

7. *Other Terms and Conditions:*—

- (i) The grant of financial assistance under these rules cannot be claimed as a matter of right.
- (ii) A person whose family income from all the sources does not exceed Rs. 25,000/- per annum is only eligible to apply for the grant of financial assistance under these Rules.
- (iii) Income Certificate shall be issued by the Panchayat Secretary in respect of applicants in Rural areas and by the Chief Officer of Municipality in respect of applicants from urban areas.
- (iv) Bonafides of the applicant shall be enquired into by the concerned Block Development Officer and the enquiry report in Appendix - III alongwith the application shall be forwarded to the Directorate of Social Welfare for consideration.
- (v) At least 30% of the beneficiaries under these Rules shall be women from each Taluka. If sufficient number of women applicants are not available, to that extent applications from men shall be entertained.

8. *Grant of Financial Assistance:*— (1) The applications received shall be scrutinised minutely by the Directorate of Social Welfare.

(2) The Director of Social Welfare shall be the sanctioning authority under these rules and his decision as regards to selection or rejection of the application for the grant of financial assistance shall be final.

9. *Cancellation/Withdrawal of financial assistance:*—

- (i) The financial assistance shall be cancelled/withdrawn if at any stage the information furnished by the applicant is found to be incorrect or that the financial assistance has been obtained by suppressing any material facts.
- (ii) The financial assistance shall be cancelled if the applicant is in receipt of financial assistance through any other sources/agencies.
- (iii) The financial assistance shall be stopped in case of death of the beneficiary before the completion of 10 years from the date of sanctioning of financial assistance. In this case, the fixed deposit shall be withdrawn by the Director from the Bank and shall be deposited in the Government Treasury.
- (iv) The financial assistance shall be stopped if the beneficiary changes his/her residential address without prior and express permission of the Director through the concerned Block Development Officer or ceases to be a resident of the State of Goa.

10. *Interpretation and relaxation.*— (1) The Director shall be the final authority concerning the interpretation of these Rules.

- (2) The Government may amend or relax any of the provisions of these Rules for good and sufficient reason/(s).

By order and in the name of the Governor of Goa.

E. Silveira, Under Secretary (Social Welfare).

Panaji, 24th June, 1997.

APPENDIX - I

(See Rule 6)

APPLICATION FORM

Application for the grant of Financial Assistance to a person with severe disability.

To,

The Block Development Officer,

I Shri/Kum./Smt. _____ furnish my particulars as mentioned below:—

- (1) Name of Applicant :
- (2) Residential Address of applicant:
- (3) Birth date of the Applicant:

- (4) Age in complete years:
(5) Whether unmarried/married:
(6) Name of father:
(7) Occupation of father of the applicant:
(only in case of minor or dependent person).
(8) Occupation of mother of the applicant
(only in case of minor dependent person)
(9) (i) Name of the husband in case
of married women:
(ii) Occupation of the husband:
(10) Total family income per annum.

(11) Particulars of other family members of the applicant:

Name	Age	Relationship with the appli- cant.	Occupation	Income
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				

I, Shri/Kum./Smt. _____ do
hereby solemnly affirm that the information furnished above is true
and correct to the best of my/our knowledge and belief.

Place:

Signature of the applicant

Date:

Signature of parents

(In case the applicant is minor
and/or in case of mentally
retarded applicant).

Mother: _____

Father: _____

Documents required to be attached:

(Please tick () whichever is attached against the following)

- (1) Birth Certificate issued by the office of the Registrar of Births
& Deaths failing which a school leaving certificate indicating
date of birth failing which any other document in support of birth
date from any competent authority.

- (2) Medical Certificate from Asilo Hospital, Mapusa or Hospicio
Hospital, Margao or G.M.C., Bambolim or Institute of Psychia-
try and Human Behaviour, Altinho, Panaji.
(3) Residence Certificate issued by the Mamlatdar of the concerned
Taluka (In case the applicant is from an Urban area) and
issued by the Sarpanch of concerned Village Panchayat and
countersigned by the Block Development Officer of the respec-
tive Taluka/Block (In case the applicant is from a rural area).
(4) Family income certificate issued by the Mamlatdar of the
concerned taluka.
(5) Family income of the person shall consist of income from all
sources of the person inclusive of income from all sources of
his/her parents/guardians his/her husband or wife (if married)
and unmarried brothers and sisters (if any) and his/her unmar-
ried children (if any).
(6) Declaration in Appendix - II.
(7) Certificate of the concerned B.D.O. in Appendix - III.

APPENDIX - II

[See rule 6 (2)]

Declaration to be signed by the applicant who has applied for the
financial assistance under the Scheme for Grant of Financial Assistance
to a persons with severe disabilities.

DECLARATION

I, Shri/Kum/Smt. _____
hereby declare that I am a person with severe disabilities. Further, it is
declared that I stay _____ (Name of the
place or residence) at the residential address as stated in the application.
I declare that I am not in receipt of any type of financial assistance under
any or the Schemes of the State or Central Government.

I also declare that I/we have not concealed any material facts and
willfully suppressed information which is contradictory to what is stated
in the application.

Signature of applicant:

Signature of parents in case
the applicant is minor and or
in case of mentally retarded
applicant.

Signature and
Office Seal of the
concerned B.D.O.

Father:

Mother:

or

Guardians (i) _____

(ii) _____

Place:-

Place:-

Date:-

Date:-

APPENDIX - III

[See clause (iv) of Rule 7]

CERTIFICATE OF THE BLOCK DEVELOPMENT OFFICER

I certify that on enquiry the particulars given above are found to be correct. Further, it is certified that Shri/Kum./Smt. _____ seeking the grant of financial assistance under the Scheme for "Grant of Financial Assistance to persons with severe disabilities", is a disabled person and is residing at _____ at the residential address stated in the application.

Date:

Signature with Official seal
of Block Development Officer.

APPENDIX - IV

[See rule 6(1)]

MEDICAL CERTIFICATE IN RESPECT OF AN
ORTHOPAEDICALLY HANDICAPPED CANDIDATE

Certified that, I, Dr. _____
Registration No. _____ have this
_____ day of _____ 19 _____ examined
that the candidate whose particulars are given below:

(1) Full Name of the Patient/Applicant:

(2) Name of Father/Husband:

(3) Age in years:

(4) Sex:

(5) Marital Status:

(6) Residential Address:

House No.
Village/Town
District

Wado/Ward
Taluka
State

(7) Identification marks:

(8) Nature of Disability:

(9) Is the disability
temporary or permanent:

(10) Extent of disability
estimated in percentage
as per ALIMCO MANUAL/
Schedule I to the
WORKMEN'S COMPENSATION
ACT, 1923 (8 of 1923).

(11) Any operative procedure
done on advise:

(12) Is the patient/applicant
willing to undergo
treatment:

(13) Whether the handicapped
would need any artificial
aid at any stage? If yes,
give full details of the
artificial aid:

(14) Whether the Artificial Aid
is to be used by the Handicapped
immediately and/or
after operative surgery:

(15) Any other particulars or
comments regarding the
disability that the certifying
authority may like to note:

(16) When necessary, attach and
countersign the photograph
of the patient/applicant
showing his nature of
disability and any appliance,
if used:

Signature/Left Hand Thumb impression of the
patient/candidate

Photograph

Signature of Orthopaedics Surgeon

Name:

Registration No.

Designation
with seal

APPENDIX - V

[See rule 6 (1)]

MEDICAL CERTIFICATE FOR THE BLIND

Certified that I, Dr. _____
Registration No. _____ have this
_____ day of _____ 19 _____ examined the candidate
whose particulars are given below:

(1) Name of candidate:

(2) Father's Name:

(3) Sex:

(4) Approximate Age:

(5) Identification Mark:

(6) Extent of residual vision, if any, R.E.
Vision, if any L.E.

(7) Onset of Blindness (please state whether blindness is from birth
or acquired later, if it has been caused afterwards, the age and
cause of blindness may be indicated)

(for the issue of Identity card, the blind those who suffer from
either of the following):

(a) Total absence of sight:

(i) Right Ear.

(b) Visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye with correcting lenses:

(ii) Left Ear.

(c) Limitation of the field of vision subtending an angle of 20 degrees or worse:

(7) Onset of deafness (Please state whether deafness is from birth or acquired later. If it has been caused afterwards, the age and cause of deafness may be indicated).

(8) Please specify the percentage of visual disability.

(8) Please state clearly whether the candidate is deaf for the purpose of financial assistance?

(Signature of the Applicant)

(Signature of Ophthalmologist)

Place:

Designation

Office Stamp:

Date:

Address:

(9) Please enclose autogram chart.

(Signature of the candidate)

(Signature of the ENT Specialist)

Designation:

Office Stamp:

Address:

Place:

Date:

APPENDIX - VI

[See rule 6 (1)]

MEDICAL CERTIFICATE FOR THE HEARING HANDICAPPED

Certified that I, Dr. _____

Registration No. _____ have

this _____ day of _____ 19 _____

examined the candidate whose particulars are given below:-

(1) Name of Candidate:

(2) Father's Name:

(3) Sex:

(4) Approximate Age:

(5) Identification Mark:

(6) An estimate of the residual hearing, if any, and the basis on which this estimate has been arrived at.

APPENDIX - VII

[See rule 6 (1)]

MEDICAL CERTIFICATE FOR THE MENTALLY RETARDED

Certified that I, Dr. _____

Registration No. _____ have this _____ day

of _____ 19 _____, examined the

candidate, whose particulars are given below and that he/she falls within the definition of mentally retarded.

(1) Name of the candidate:

(2) Father's Name:

(3) Sex:

(4) Approximate age:

(5) Identification mark:

- (6) (a) Please state whether the candidate is mentally retarded since birth or became so later; the age and cause of mental retardation or mental deficiency may be indicated; (For the purpose of scholarships, the Mental Retardation can be defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the *developmental period. Adaptive Behaviour is defined as the effectivity or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group.

*(Developmental period extends upto the age of 18 years).

- (b) Extent of mental retardation or mental handicap. Estimate in I.Q. level below 70 is considered mentally retarded.
- (7) Please state clearly whether the candidate is mentally retarded for the purpose of scholarship.

- 8) Any other particulars to clarify the extent of mentally retardation or mental handicap which the Clinical Psychologist or Psychiatrist would like to point out.

- (9) Please state the training capability of the individual and the type of training for which he is suitable.

Signature of the Candidate.

Signature of the Clinical
Psychologist or Psychiatrist

Designation:

Office Stamp:

Place:

Address:

Date: